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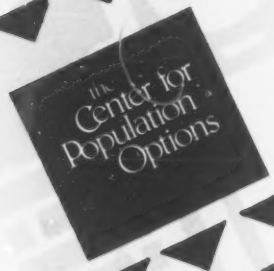
School-Based Clinics



Update 1990

By H. Jean Hyche-Williams, M.S.W., Ed.D., and Cynthia Waszak

CPO AND THE SUPPORT CENTER

The Support Center for School-Based Clinics, a project of CPO, is a national resource for practitioners serving young people with comprehensive health care in a school-related setting. Begun in 1985, the Support Center works to facilitate communication among SBC practitioners, policymakers and advocates, assists in program development, consults on program operations, cooperates in the evaluation of the SBC model, assesses public policy initiatives and projects trends for the field. The Support Center provides technical assistance, training, an annual conference, publications and a quarterly newsletter on program and policy developments.

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FOREWORD

Nearly 20 years after the opening of the first school-based clinic (SBC), new clinics continue to emerge, and established clinics continue to expand the scope of their services. During the same period, school-linked clinics* have also been developing as a model which exclusively serve the health care needs of teens.

Many people think of the period of adolescence as a time of good health and happy times. If this is true, why then has there been this apparent need and subsequent growth of SBCs and other teen health care models?

More data are available on this period of growth and development than ever before. Yet a great deal of this information is not encouraging, especially as it relates to the overall health of teens. Adolescence is normally a period of experimentation; now, statistics suggest that adolescents are engaging in more risk-taking behaviors than ever before. And, it is occurring at earlier and earlier ages.[1]

The headlines describe the results of these behaviors: high rates of teen pregnancy, homicide, suicide, highway accidents and the list goes on.... Teens are in trouble and so are we!

Communities which have SBCs and other teen health facilities recognize this fact and look to these resources as a way of addressing some of the problems. Although the number of SBCs has grown, there are not nearly enough. Yes, they can be controversial; but it is our hope that the controversy will not diminish our concern and instead will call for action on behalf of those adolescents who are still in need. As Sharon Lovick, the former Director of the Support Center, so aptly stated, "At a time when so many teens remain in need, it would be tragic if a few vocal critics succeeded in stopping a movement that has developed through the committed efforts of many communities and individuals."[2]

This UPDATE is designed to provide information to those seeking to learn more about school-based clinics. It gives a profile of the SBCs as they currently exist, including who they serve, what services they provide, who sponsors them and who uses them. Other aspects of school-based clinics are highlighted as well. It is our hope at the Support Center/CPO that proponents and advocates of adolescent health care in general, and school-based clinics in particular, will find UPDATE 1990 helpful in their efforts on behalf of adolescents.

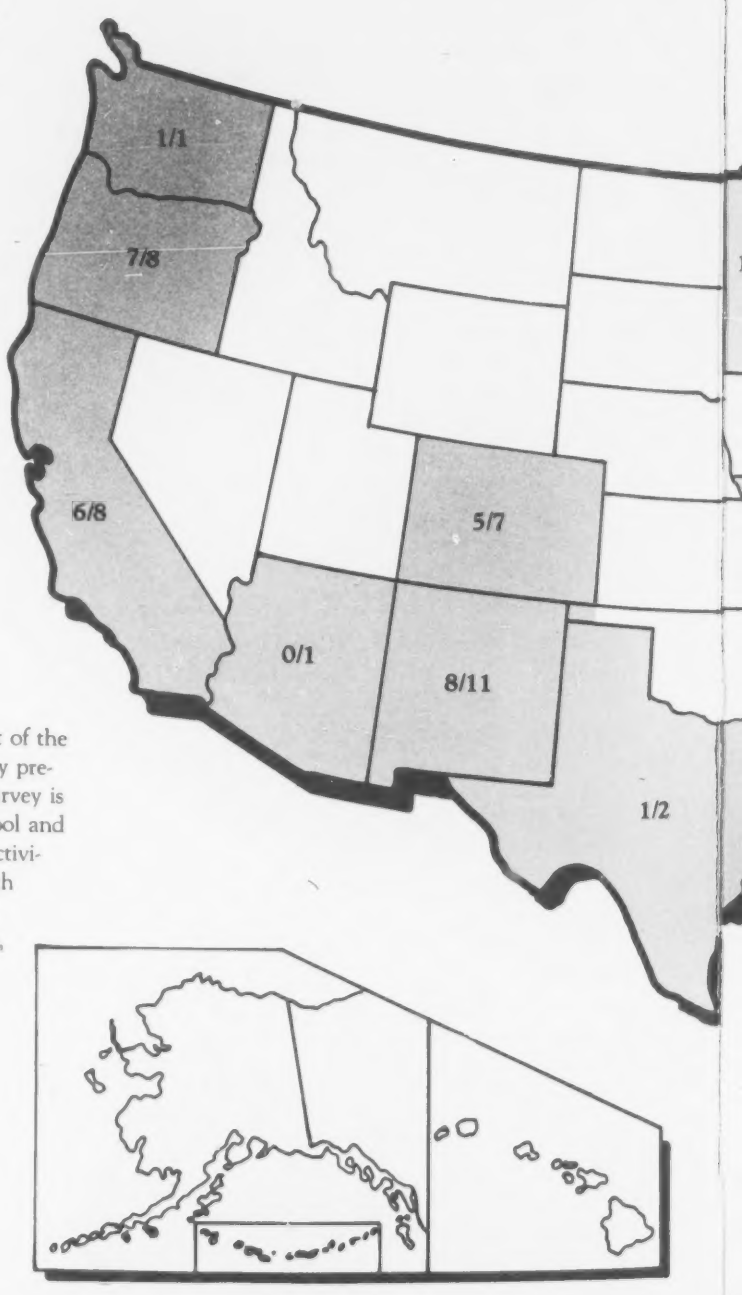
*School-linked clinics in this context refer to adolescent health care facilities which are not located within a school facility or on the school grounds, but have established linkages with schools for referrals and other purposes.

THE SURVEY

Since 1985, the Support Center/CPO has compiled descriptive and quantitative information on school-based clinics, providing the major statistical resource for school-based clinic practitioners, policymakers and advocates. Data collection is an on-going process, utilizing a variety of techniques; however, each spring the Center has conducted a survey which collects detailed information on existing SBCs.

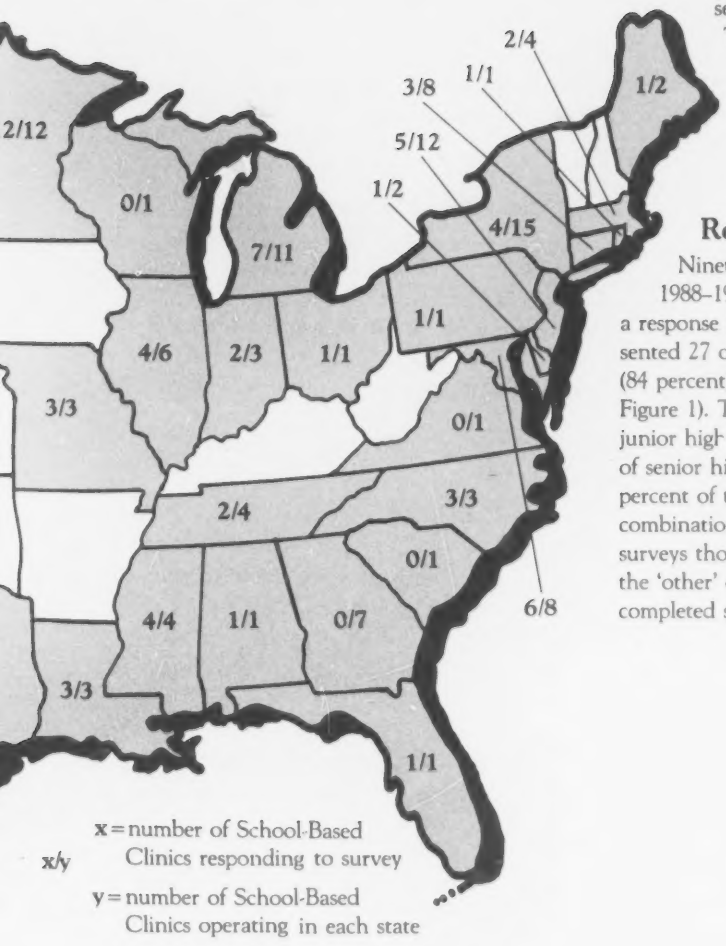
The survey, which is mailed to clinic administrators, provides the data base on school-based clinics for this analysis. Recognizing the inherent difficulties in mail survey research, especially the low response rates, the Support Center is always encouraged by the level of participation in the annual survey. One likely reason is that the questionnaire, though lengthy, has relevance and value to the respondents.

Notwithstanding the level and degree of interest of the SBC constituency, several additional factors may preclude an even higher response rate. First, the survey is sent near the end of the school term when school and clinic staff are involved in special or close out activities, developing funding proposals and other such tasks. Secondly, many clinics may lack accurate procedures for collecting data and are, therefore, simply unable to respond to requests for information quickly. Despite these limitations, the survey continues to provide important information about a large number of school-based clinics, and adds to our knowledge and insights about the delivery of health services to adolescents within the school setting.



The Survey Instrument

Mailed in February and March of 1990, a nine page survey instrument requested information on clinic locations, sponsoring organizations, users, services, staffing patterns and other details. The instrument contained both structured and open-ended items for clinics operating in the spring semester of 1989 (school year 1988–89.)



Response Rate

Ninety-five of the 153 clinics operating during the 1988–1989 school year returned completed surveys for a response rate of 62 percent. These respondents represented 27 of the 32 states in which SBCs are located (84 percent) and 56 of the 96 cities (58 percent). (See Figure 1). The response rates were slightly different for junior high/middle and senior high schools: 66 percent of senior highs with SBCs returned surveys as did 52 percent of the junior high/middle schools. All of the combination junior and senior high schools completed surveys though only two of the 11 schools classified in the 'other' category—vocational-technical, K–12—completed surveys.

THE CLINICS

TABLE 1. Percentages of SBCs by type of sponsoring agency.*

	All Schools (n=94)
Agency	
Public health department	33
School system	19
Community clinic	18
Hospital	18
Other	3
Mean number of SBCs sponsored per agency	1.7

*More than one agency may be identified for any one clinic.

Last year we reported that in 1988, 150 school-based clinics were operating in middle, junior and senior high schools. In 1989, (the time period for which this survey reports), a total of 153 clinics were identified. Although the SBCs in the survey represent a diverse array of programs, they appear to have a common mission: to develop innovative health programs for the adolescent school age population.

Sponsoring agencies

The 95 clinics in our sample were administered by 57 different agencies (mean clinics per agency = 1.7). (Table 1). The greatest percentage of clinics were administered by public health departments (33 percent), followed by school systems (19 percent). Hospitals and community clinics each administered 18 percent of the clinics.

Operation

Eighty-three percent of the clinics operate every weekday. Ninety percent are open either before or after school, 53 percent are open during the summer and almost a quarter of them are open on holidays.

Enrollment

Clinic enrollment averaged 711 clients, with a range of 130 to 3000. The average number of clients using the clinic during the school year was 569 with a range of 43 to 2238. The average number of visits was 2018, with a range of 116 to 6288, and the average number of encounters was 2483.

In The School

In The Community

The clinic and the school are two different environments, each with a unique climate and attendant values, procedures and consumers. In this special relationship, a partnership develops which blends the two systems to improve the quality of life for adolescents. The host schools and communities can provide a model for the study of intersystemic linkages and program development. SBC schools in the sample provide assistance in a variety of ways, including space, in-kind services and funding.

Location and Enrollment

Ninety-one percent of all clinics in 1989 were located inside the main school building. The remaining nine percent were located in separate buildings on the school campus. The average school enrollments for schools with SBCs was 1527 students, ranging from 315 to 10,000.

Because of the sometimes controversial nature of SBCs, those communities in which they develop, in addition to perceiving a need to expand health care for adolescents, have citizens who actively participate and serve as strong advocates for adolescents in general and the SBC in particular.

Advisory Boards

Eighty-three percent of the SBCs responding had advisory boards. Of those SBCs with advisory boards, 86 percent reviewed policy, 68 percent represented their SBC for the media, 31 percent did fundraising, 34 percent developed policy and 25 percent had other functions such as brainstorming on program improvements, planning school/clinic functions and seminars, advising on adolescent needs and issues and volunteering in the SBC.

THE SERVICES

TABLE 2. Percentages of clinics which offer medical services, by type of school.

	Type of School		
	Senior High (n=76)	Junior High/Middle (n=11)	All Schools (n=95)*
Medical services			
Assessment/ referral to community health care	93	55	90
Assessment/ referral to private physician	90	55	85
Chronic illness management	87	100	87
Dental services	28	55	31
Diagnosis/ treatment of minor injuries	99	100	98
Diagnosis/ treatment of STDs	92	82	90
Dispense medication	72	82	74
EPSDT screening	49	55	48
General physicals	96	100	96
General primary health care	97	100	97
Gynecological exams	90	91	88
Immunizations	90	100	87
Laboratory tests	97	100	97
Pediatric care for infants of adolescents	38	18	38
Physical exams for sports/work	97	100	97
Pregnancy tests	93	91	93
Prenatal care (on-site)	38	18	36
Prescribe medication	92	100	92
Referral for prenatal care	91	100	91

*ALL SCHOOLS includes the responses of combination schools and other schools.

After the local community has determined the need and location for a school-based clinic, a critical next step becomes the actual delivery of services. Although most communities want to provide medical services, they often shy away from controversial services, such as reproductive health care.

Medical

The *medical services* offered by the greatest percentage of SBCs included general and sports physicals, diagnosis and treatment of minor injuries and STDs, gynecological exams, pregnancy tests, immunizations, laboratory tests, chronic illness management and assessment and referral to community health care or to private physicians. (Table 2). Over 90 percent prescribed medications for their clients. Only about 31 percent of all clinics offered dental services.

The percentages of SBCs at junior high/middle and senior high schools were similar with regard to the provision of most medical services. However, a larger percentage of senior high than junior high/middle school clinics did assessments and made referrals to other sources of care and provided pediatric care for infants of clients. On the other hand, a larger percentage of junior high/middle than senior high clinics provided dental care for their clients.

Counseling/Educational

The most commonly reported counseling services included: mental health/psychosocial, sexuality, pregnancy, family and drug and substance abuse counseling; and nutrition and weight reduction education programs. Services offered more often in senior high than junior high/middle schools included job counseling, parenting education and sexuality education in the classroom. (Table 3).

Reproductive Health

Reproductive health care for adolescents continued to be a highly sensitive issue which SBCs must address. Although there were relative increases in the percentages of SBCs that prescribed and dispensed contraceptives, many still avoided the issue. They usually addressed the issue by referring the student to an outside health provider. Some even attempted to sidestep the issue altogether by publicly stating they were not providing these services.

Family planning services offered most often included counseling and examination for birth control methods and follow-up and referral for birth control methods. (Table 4). Over half of all clinics in this sample wrote prescriptions for birth control methods, while only 21 percent actually dispensed birth control products. Slightly more junior high/middle than high schools dispensed contraceptives. A higher percentage of senior high than junior high/middle schools did birth control counseling, examinations for birth control, follow-ups or referrals for birth control.

Other Services

Less than half the clinics provided a structured HIV prevention program in the classroom or in the clinic. Only 12 percent provided daycare for children of students.

TABLE 3. Percentages of clinics which offer counseling/educational services, by type of school.

	Type of School		
	Senior High (n=76)	Junior High/Middle (n=11)	All Schools (n=95)*
Counseling/ educational services			
Drug and substance abuse programs	63	73	66
Family counseling with students and parents	83	73	82
Health education	100	100	100
Job counseling	32	9	30
Mental health and psycho-social counseling	91	82	91
Nutrition education	100	100	99
Parenting education	65	46	62
Pregnancy counseling	92	91	91
Sex education in classroom setting	87	73	85
Sexuality counseling	97	91	96
Weight reduction programs	91	82	90

*ALL SCHOOLS includes the responses of combination schools and other schools.

THE STAFF

Other services that clinics provided included: peer counseling programs, parenting classes for teen parents and support groups for issues such as children of alcoholics, survivors of rape, incest and sexual abuse and students dealing with bereavement and adjustment disorders. Other programs included stress management and assertiveness training, HIV prevention seminars and individual and group counseling sessions. SBCs also sponsored school clubs and weekend retreats.

TABLE 4. Percentages of clinics which offer family planning services, by type of school.

	Type of School		
	Senior High (n=76)	Junior High/Middle (n=11)	All Schools (n=95)*
Family planning services			
Counseling on birth control methods	97	73	94
Dispensing birth control methods	20	27	21
Examinations for birth control methods	72	55	70
Follow-up for birth control methods	80	55	78
Referrals for birth control methods and exam	72	46	71
Writing prescriptions for birth control methods	55	55	54

*ALL SCHOOLS includes the responses of combination schools and other schools.

The range of staffing patterns among SBCs continued to be large and varied. Administrative tasks were as likely to be assigned to medical or health professionals as to non-medical personnel. Creative and flexible staffing is often the "glue" that holds many underfunded, understaffed clinics together and enables SBCs to provide services that otherwise would not be available.

Twenty-nine percent had full-time clinic managers while 12 percent had part-time directors. Clinics reported an average of one full-time and two part-time medical staff members. Three percent of the clinics listed dentists as members of the part-time staff. Clinics had an average of one part-time counselor/educator and about half the clinics had one full-time counselor/educator. Type of staff who were reported in 25 percent or fewer schools were part-time and full-time administrative positions, interns, athletic trainers, researchers, therapists and community relations personnel.

School Nurse

Eighty-two percent of the SBCs in our survey were in schools where a school nurse was present. Forty-four percent of the school nurses in these schools served as

part of the SBC staff. These percentages have remained relatively constant since our initial survey. Many clinics reported that there was coordination and integration between the school nurse and SBC. Even in those schools where the school nurses did not serve on the SBC staff, nearly all referred students to the clinic.

In the schools where the nurse worked as part of the SBC staff, his or her role often involved delivering primary care or providing case management services. The nurse also served as a key referral agent and assisted in providing health education in collaboration with SBC programs. The nurse also participated in clinic staff meetings and case conferences, served on program advisory boards, provided SBC and school staff in-service training and assisted in program development. Overall, the role of the school nurse can be a vital link between the school and the clinic. Survey responses indicated that the school nurse and the SBC staff had discrete responsibilities which were complementary in expanding and improving the scope of services provided to students.

FINANCES

SBCs depend on a combination of public and private funds for their operation. The average operating budget for the clinics in our survey was $143,827. The mean numbers of dollars from each funding source are listed in Table 5. State health departments (28 percent), private foundations (26 percent) and city governments (19 percent) provided the greatest percentages of funds to SBCs. SBCs continue to face formidable challenges in funding their continuing operations and have become creative in their approaches. A great many reported heavy reliance on in-kind contributions—from provision of space to actual staffing from other organizations.

TABLE 5. Operating budget by funding source (n=79).

Funding source	Mean Dollars	% Total Budget
MCH	16,524	11
EPSDT	4,111	2
Medicaid	5,184	3
Title XX	317	<1
School District	2,930	2
Community Health Center	6,346	4
State Health Department	40,972	28
City	27,556	19
Private Foundation	38,698	26
Private Insurance	3,830	2
Student Fees	263	<1
Other	4,348	2
Total	143,827	100
Range	(0–600,001)*	

*Zero indicates that the clinics receive in-kind contributions only; two clinics indicated they receive no actual dollars.

TABLE 6. **Mean and range of percentages of male and female clinic users and varying ethnic backgrounds, by type of school.**

	Type of School			
	Senior High	Junior High	All Schools*	
Gender				
Male				
Mean	43	46	44	
Range				17–71
(N)				(82)
Female				
Mean	57	54	56	
Range				29–83
(N)				(82)
Ethnic background				
White				
Mean	31	26	31	
Range				0–100
(N)				(77)
Black				
Mean	44	63	45	
Range				0–100
(N)				(78)
Hispanic				
Mean	18	8	16	
Range				0–88
(N)				(77)
Asian				
Mean	3	1	3	
Range				0–23
(N)				(77)
Other				
Mean	5	2	6	
Range				0–80
(N)				(77)

*ALL SCHOOLS includes the responses of combination schools and other schools.

All SBCs reported that they will enroll any student attending their school. They vary in the degree to which they will serve those who are not students: 30 percent will serve dropouts, 36 percent will see students from other schools, 31 percent will see children of students, 11 percent will serve siblings of students and 10 percent will serve any adolescent in the target area. SBCs in senior high schools are more likely than those in junior high/middle schools to serve adolescents not enrolled in school.

The average percentage of male clinic users among the clinics in our sample was 44. Clinic users tend to reflect the racial and ethnic make-up of the total target school population. (Table 6). An average of 31 percent of clinic users were white, 45 percent were black, 16 percent were Hispanic, 3 percent were Asian and 6 percent were coded as "other," (many others were actually noted as American Indians). There were differences between junior high/middle and high schools with regard to the percentages of blacks and Hispanics. The average percentage of black clients was 44 in senior highs and 63 percent in junior high/middle schools, while the average percentage of Hispanics in senior highs was 18 percent and in junior high/middle schools was 8 percent.

Parental Consent and Involvement

Nearly 90 percent of all clinics required some type of parental consent before the student enrolls in the clinic. Of the clinics which require parental consent, 29 percent list the services which require parental consent, 29 percent list the services available and give parents the option to check off any services they do not wish their children to receive. Twenty-seven percent simply list the services. Seventeen percent list the ser-

POLICY ACTION

vices and also give notice that some services may be received without parental consent as authorized by state law. Another 17 percent have different types of parental consent, such as a combination of several identified above. In several Minnesota clinics, three different types of parental consent are possible: one lists all services; one lists all except family planning; one allows parents to deny all access to services for their children. Additionally, these Minnesota clinics inform parents about minor consent laws, which allow confidential services without parental consent. Only 10 percent of the clinics responding indicated that parents check off the services they wish their children to receive.

Many clinics offer at least some services without parental consent. Fifty-seven percent allow emergency services without consent; 43 percent offer family planning services without consent and 47 percent will treat STDs without consent. Senior high schools tended to be less conservative with regard to the issue of consent than junior high schools, reflecting the age difference of their clients.

Although the SBC maintains patient confidentiality, adolescents are encouraged to involve adults in their lives. Parents are kept informed of clinic activities and are encouraged to become involved in clinic planning and in advisory groups.

Thirty-seven programs in 14 states reported that some type of policy action had been initiated related to school-based clinics. Thirteen indicated that the policy action was concerned with family planning-services. Five initiatives resulted in restricting family planning services in the SBCs involved in prescribing and/or dispensing contraceptives. Seven respondents reported that the policy action to restrict family planning services had not been achieved. Several respondents felt that the restrictive policy action was due to negative press on SBCs, misunderstanding in the community about SBCs or failure of SBC advocates to mobilize supporters.

On the positive side, 22 respondents stated that policy action had been undertaken to extend SBC services, with 13 reporting that, in most instances, success resulted in additional funding.

Latest Developments

In addition to the data gathered through the survey, the Support Center for School-Based Clinics collects data on new and developing SBCs. This information can serve as an indication of interest in adolescent health care for a particular geographic area or the nation in general. The current status of established and developing SBCs is reflected below:

SBC Count

August 1990
178 clinics operating

16 clinics in the planning stage

Table 7. Trends in school-based clinic growth academic years 1984–85 to 1988–89

Year	Number of SBCs
1984–85	61
1985–86	85
1986–87	120
1987–88	150
1988–89	153

Summary and Conclusions

The SBC in many communities has become the hub of services for adolescents and has valuable information on their health needs. **Thus, further investigation should be directed toward learning more about the types of health care for which senior high students are referred.** This information could provide guidance for the development of prevention programs for SBCs at the junior high/middle school level and for other community-based programs.

Each year we are learning more about what is provided, what services are used and who is using these services. It is clear that clinics in/or connected to schools provide a needed resource and continue to expand—despite a difficult political environment—in order to meet a high demand for quality, comprehensive health care.

Still Growing

Survey results and experiences with a variety of school-based clinics over the past five years suggest that the model is becoming more acceptable to more communities. Consider the growth from 61 SBCs when we conducted our first survey in 1986 to the 153 clinics known to the Support Center at the time of this year's survey. This represents an increase (in actual numbers) of 92 or a rate of 151 percent. The rate of growth of SBCs has been accompanied by an increase in the number of junior high/middle school clinics. In 1986, our UPDATE reported on 15, and this year's UPDATE shows a total of 21. We have learned that junior high/middle schools offer similar services as high schools though the latter have greater numbers of assessments and referrals to other sources of care. The table below shows the trends in school-based clinic growth.

Funding

As the movement has grown and initial start-up grants have expired, SBCs have had to compete with other programs for scarce resources. Therefore, funding and staffing concerns are becoming more prevalent, forcing clinics to become creative in their utilization of these resources. On the positive side, however, more local communities are assuming greater fiscal responsibility for SBCs, often providing in-kind services. One major source of increased support has come from the school nurse, who is working more with the SBC. This support serves as a vital link between the school and the clinic.

Male Outreach

School-based clinics do a good job of reaching those who are typically difficult to reach in health programs, such as young males. Last year we reported that an average of 38 percent of the clinic users were male. This year's survey shows that 44 percent are males. These numbers seem to support one recent study which found that school-based clinics saw a larger proportion of males than did other adolescent health programs. Many SBCs are now directing and offering programs which place greater emphasis on male responsibility in general and family planning in particular.[3] They have aggressive outreach programs to males and whenever possible, hire males and/or recruit male volunteers for special projects.

TABLE 8. Percentages of clinics which offer family planning services, by school year.

	School Year	
	1987–88	1988–89
Family Planning Services		
Counseling on birth control methods	85	94
Dispensing birth control methods	12	21
Examinations for birth control methods	55	70
Follow-up for birth control methods	71	78
Referrals for birth control methods and exam	72	71
Writing prescriptions for birth control methods	43	54

Reproductive Health Care

Despite the controversy in some areas concerning the provision of reproductive health care for adolescents, this year's survey is encouraging. Family planning services appear to be available in more clinics than previously reported. Counseling on birth control methods increased from 85 percent in last year's report to 94 percent this year. Also, more clinics reported in this year's survey that they dispensed and prescribed birth control methods. The table below compares percentages of clinics which offered family planning services in 1987–88 and 1988–89.

While it is too early to draw conclusions concerning the apparent increase in the number of schools providing reproductive health services, future studies should examine the characteristics and qualities of those schools and communities in which these services are offered. Our survey asked respondents to provide information on any restrictive state policy action initiated in reproductive health care. Twelve respondents indicated that attempts had been made in their states. Of the 12, seven reported that policy action to restrict family planning had been unsuccessful due to actions of their advisory boards, which can play an indispensable role in the life of a clinic. With the increasing number and visibility of SBCs and with funding shifts to more public sources, clinics will face greater scrutiny and controversy. And advisory boards can serve to enlighten the public about the benefits of SBCs. **Future studies should investigate the extent to which advisory boards play a role in a clinic's ability to provide reproductive health care.**

If we are earnest in our goals to reduce risk-taking behaviors and improve life options for adolescents, we must continue to expand our network of supporters and seize every available opportunity to inform and educate the public. The goals are lofty, yet many believe and insist that they can be achieved if they are actively sought after by a caring network of not only SBC advocates, but the broader community as well. Only then will we continue to increase the number of SBCs and other adolescent health models such as school-linked clinics, all of which hold the promise of providing for the well-being of many teens who are still in need.

REFERENCES

[1]The National Commission on the Role of the School and the Community in Improving Adolescent Health, "Code Blue: Uniting for Healthier Youth," 1990.

[2]S.R. Lovick, "The School-Based Clinic Update 1987," CPO/Support Center for School-Based Clinics, Houston, Texas, 1987.

[3]F. Earls, L.N. Robins, A.R. Stiffman and J. Powell, "Comprehensive Health Care for High-Risk Adolescents: An Evaluation Study," Journal of the American Public Health Association, 79:999-1005, 1989.